AMERICAN SOCIETY OF CRIME LABORATORY DIRECTORS
LABORATORY ACCREDITATION BOARD (ASCLD/LAB)

ANNUAL ACCREDITATION AUDIT REPORT FROM August 3, 2012 to August 3, 2013

Indicate the period of activity above. The period should include a full year from accreditation anniversary to the next anniversary. The Annual Report is due on or within 60 days after the laboratory's anniversary date.

Accreditation Certificate Number (Submit a separate form for each certificate number): 324

Laboratory Name: Austin Police Department

Agency Name: Austin Police Department

LABORATORY DIRECTOR: Check if changed since the last report ☐

Name: William Gibbens Title: Forensic Division Manager

Street / Mailing Address: 812 Springdale Road/PO Box 689001

City: Austin State/Province: TX Zip/Postal Code: 78768-9001

Country: USA Telephone: 512-974-5118 Fax: 512-974-6640

E-mail: bill.gibbens@austintexas.gov

NAME OF SYSTEM DIRECTOR (if applicable):

QUALITY MANAGER: Check if changed since the last report ☐

Name: Tony Arnold Title: Quality Assurance Manager

Telephone: 512-974-5103 Fax: 512-974-6640

E-mail: tony.arnold@austintexas.gov

LABORATORY DELEGATE (Check one)

☒ The Laboratory Director listed above is the Delegate.

☐ As Laboratory Director, I have named the following individual as the Delegate for this laboratory:

Name: Title:

Telephone: Fax:

E-mail:

SELF-EVALUATION OF COMPLIANCE

Using standards and criteria in the most current Accreditation Manual, a self-evaluation of your laboratory operations should form the basis for completing the following table.

	Total Number Possible	Total Yes	Total No	Total N/A	Percentage Yes
Essential	91	68	6	17	92
Important	45	38	5	2	43
Desirable	16	15	1	0	94

While the current manual should always be used for annual audits, laboratories which were accredited under the standards and criteria of an earlier version of the manual are not required to be in compliance with new standards which were added or raised to essential after their accreditation. **However, laboratories must include a statement concerning such standards, which they do not meet, to indicate the steps that are being taken to move toward compliance with those standards and criteria.**

This report must include explanations of any essential criteria scored "No" during the self-evaluation.

PERSONNEL

Total number of employees subject to proficiency testing (including vacancies): 60

The total number of employees subject to proficiency testing (including vacancies) is an important number and should be accurately determined. This is the number used to calculate your laboratory's shares for the annual administrative fee. The number should not include administrative or clerical personnel. The number does include all laboratory positions subject to proficiency testing, whether in training, providing technical support or currently vacant.

IMPORTANT . . . If the response to any of the following is YES, please attach an explanation

During the past year:

- Did the annual audit reveal any instance of substantive non-compliance with any ***Essential*** criteria? …….. …… ☒ Yes ☐ No

The primary purpose of the *Annual Accreditation Audit Report* is to document that the laboratory has made at least an annual determination that operations continue to be in compliance with accreditation standards, with a particular focus on *Essential* criteria. Laboratories must report *substantive* occurrences of non-compliance with essential criteria. "Substantive" means potentially having a significant bearing on the quality of the work of the laboratory, even if for a short period of time. With the expectation that a laboratory will always react internally and appropriately to instances of known non-compliance, it is not necessary to report every isolated occurrence of non-compliance. For deciding upon inclusion in this report, factors such as significance, substance and time-span of non-compliance should be evaluated. When in doubt, include the finding in your report.

- Was any discipline or sub-discipline added, reinstated, or suspended? …… ☐ Yes ☒ No

  List the discipline(s), action(s) taken and date: _____

- Did an inconsistency or error on a proficiency test occur that required corrective action to be implemented? ……..…… ☒ Yes ☐ No

- Did an inconsistency or error on casework occur that required corrective action to be implemented? ……..…… ☒ Yes ☐ No

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IMPORTANT . . . If the response to the following is NO, please attach an explanation

- Did the laboratory meet the external proficiency testing requirements of each discipline, including the submission of all test results by the test provider's deadline? …… ☒ Yes ☐ No

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SIGNATURE (A typed name should be inserted for reports submitted via E-mail)

William Gibbens	August 9, 2013
Laboratory Director	Date

INSTRUCTIONS

- Reports may be submitted electronically to tdolin@ascld-lab.org
  or mailed to: ASCLD/LAB, 139 J Technology Drive, Garner, NC 27529
- Questions about the completion of the *Annual Accreditation Audit Report* may be addressed to ASCLD/LAB at 919-773-2600 or mcreasy@ascld-lab.org

Every laboratory must submit an *Annual Accreditation Audit Report* to ASCLD/LAB on or within 60 days of the anniversary date of the laboratory's accreditation. This report and supporting documentation can serve as proof of an annual audit (1.4.2.3). Laboratories applying for accreditation must conduct an audit in order to complete the Grade Computation Sheets and other supporting documents required with the application. Those documents may serve as proof of an audit for the purpose of the accreditation inspection. Laboratories having an inspection for renewal of accreditation, may utilize the application documents and inspection report as supporting documentation of an audit for the year in which the inspection is conducted. While appropriate as supporting documentation, neither the

application for renewal, nor the subsequent inspection report replaces the required *Annual Accreditation Audit Report*.

M E M O R A N D U M

Austin Police Department
Field Support Services
Forensic Science Division

TO: Bill Gibbens, Division Manager
FROM: Tony Arnold, Quality Assurance Manager
DATE: August 8, 2013
SUBJECT: 2013 Annual Internal Audit

The Austin Police Department Forensic Science Division conducted its annual internal ASCLD/LAB accreditation audit during the month of June 2012. The audit was conducted by K. Sanchez, R. Salazar, I. Farrell, G. Karim, S. Siegel, C. Carradine, J. Pena, B. Gibbens, J. Guerrero, T. Arnold and E. Morris. The audit consisted of examining the lab utilizing the criteria described in the 2008 ASCLD/LAB Legacy Program accreditation guidelines. The Laboratory was found to be non-compliant to the following standards. The standards, the specific issue and the remediation to take place are listed below.

Standard: Standard 1.4.2.1 (E) Does the laboratory have a comprehensive quality manual? (Control and maintenance of documentation of case records and procedure manuals)
Section: Chemistry
Issue: The division SOPs Document Management Chapter 42 Section 9A states “Superseded documents will be removed from use.” In the glass ware room there is a binder where SOP’s from the training manual are used to prepare reagents. Through interviews it was verified that these copies are used. The Revision date of the SOP’s used is 2005. The current SOP in place has a revision date of 2009.
Remediation: Out of date documents have been removed. Employees are allowed to use printed copies of the governing documents. However, it is the responsibility of the section employees to ensure that only the current versions of authorized documents are being used. *Forensic Division Standard Operating Procedures; section 3.8 Document Management*
Conclusion: Remediation accepted

Standard:	1.4.2.9 (E) Is the quality of the standard samples and reagents adequate for the procedure used?
Section:	Chemistry
Issue:	The section SOPs Drug Reference Standards Quality Assurance Section requires annual reconciliation of five randomly selected drug standards. The Drug standards were audited in July 2012. Several Drugs were identified during that time as needing reweighed or pulled for reweigh. There is no recorded follow up if these standards are all removed from general use or if they are suitable for use.
Remediation:	All drugs listed above were quality checked by supervisor on 6-20-13 and drugs determined to be what were labeled. Quality check of weights and copy of GCMS for each sample were placed in the Quality Check of Drug Standards Log Book.
Conclusion:	Remediation accepted

Standard:	1.4.2.9 (E) Is the quality of the standard samples and reagents adequate for the procedure used?
Section:	Chemistry
Issue:	The section SOP Controlled Substances Forfeited for Official Use 2.15 pg 36 states “The section supervisor or designee will periodically inventory the forfeited substance and document the results of the inventory”. The forfeiture book is incomplete and not up to date.
Remedy:	The documentation was completed by the section supervisor. The quality check weight and spectra of this sample are included in the Quality Check of Drug Standards Log Book.
Conclusion:	Remediation accepted

Standard:	1.4.2.12 (I) Are the instruments / equipment in proper working order?
Section:	Chemistry
Issue:	The section SOP Quality Assurance and Maintenance Section states that “No instrument or balance is to be used if it is not in proper working order. Instrument or balance will be tagged with a “DO NOT USE-Out of Service” notice placed on a prominent location for easy identification.” The LCMS and several balances were not in service at the time of the audit, yet no notification was in place.
Remediation:	All Equipment that is not presently being used has been tagged appropriately.

Conclusion:	Remediation accepted

Standard:	1.4.2.15 (E) Does the laboratory's unique case identifier appear on each page of examination documentation, and does the handwritten (or secure electronic equivalent) of the person generating the examination documentation appear on each page generated by that person?
Section:	Division
Issue:	The division SOPs Chapter 46 Case documentation states that "every page of each document generated outside the LIMS must exhibit the laboratory number and the initials of the employee who generated the document". Electronic documents were located throughout the division that were generated outside of LIMS and attached to the electronic case record, but did not display the required information.
Remediation:	Revisions to governing documents have been completed for implementation defining and clarify the requirements for labeling requirements of electronic documents. *Forensic Division Standard Operating Procedures; section 4 Laboratory Records*
Conclusion:	Remediation accepted

Standard:	1.4.2.16 (E) Are conclusions and opinions in reports supported by data available in the case record, and are the examination documents sufficiently detailed such that, in the absence of the examiner(s), another competent examiner or supervisor could evaluate what was done and interpret the data?
Section:	LP
Issue:	Examination information is recorded on the latent print card. This card is eventually transferred outside the division for disposition. With the inclusion of examination information on the latent print card, the card is now considered an examination document and as such must be scanned into the case folder (LIMS) prior to release from the section.
Remediation:	Revisions to governing documents have been completed for implementation requiring all examination documents to be contained in the case record. Latent print cards will be scanned into the LIMS case folder. *Forensic Division Standard Operating Procedures; section 4 Laboratory Records*
Conclusion:	Remediation accepted

Standard:	1.4.2.17 (E) Is examination documentation of a permanent nature and is it free of obliterations and erasures?

Section:	Division
Issue:	Legacy 1.4.2.17 requires the recording of the start and end dates of analysis. This information is not defined in the governing documents. There was a change by memo approved on July 13, 2012, defining the start and end dates for analysis in the chemistry laboratory. However, this change was not incorporated into the subsequent revision, as stated in the original memo. Employee interviews throughout the division indicated inconsistent answers regarding the recording of the start and end dates of analysis as required by this criterion.
Remediation:	Revisions to governing documents have been completed for implementation defining the requirements for recording the start and end date of analysis. *Forensic Division Standard Operating Procedures; section 4 laboratory Records*
Conclusion:	Remediation accepted

Standard:	1.4.3.4 (I) Does the laboratory conduct proficiency testing using re-examination or blind techniques?
Section:	Division
Issue:	Re-examination or blind testing is not practiced within the Division.
Remedy:	No action necessary
Conclusion:	The laboratory is not in compliance with this criterion for 2012.

Standard:	2.6.1 (I) Does each examiner possess a baccalaureate degree with science courses?
Section:	Firearms
Issue:	Not all examiners within the Firearms Section possess a baccalaureate degree.
Remedy:	No action necessary
Conclusion:	The laboratory is not in compliance with this criterion for 2012.

Standard:	2.8.1 (I) Does each examiner possess a baccalaureate degree with science courses?
Section:	Latent Prints
Issue:	Not all examiners possess a baccalaureate degree.
Remedy:	No action necessary
Conclusion:	The laboratory is not in compliance with this criterion for 2012.

Standard:	2.8.5 (E) Did each examiner successfully complete an annual proficiency test?
Section:	LP
Issue:	No proficiency test was completed by J. Pena for 2010.
Remediation:	No casework was performed in calendar year 2010 by J. Pena. Proficiency tests were successfully completed in 2011 and 2012; therefore, no impact to the quality of casework was indicated. No additional action is indicated.
Conclusion:	The laboratory was not in compliance with this criterion in 2010.

Standard:	3.4.6 (I) Does the laboratory have safety shower and eye wash equipment in appropriate locations and in good working condition?
Section:	CS
Issue:	The log of weekly checks was not up to date in the vehicle processing bay area. It was unclear if the safety shower is being checked regularly. This equipment is maintained by the building service personnel.
Remediation:	An email was received on July from the building maintenance personnel indicating that the safety shower was checked and found to be working properly.
Conclusion:	Remediation accepted

Standard:	3.4.12 (D) Is there general cleanliness and apparent good-housekeeping in the laboratory?
Section:	Chemistry
Issue:	In several areas of the laboratory (BAC Room, Glasswares room, Vent hoods, workbenches) unlabeled chemicals were located. These items were in various containers and were both liquids and solids. Several analysts were asked what these chemicals were and none of them were able to identify the substance or its hazard rating. Hazard labels were also missing from chemicals in the storage area and on analyst workbenches.
Remediation:	In the BAC room liquid sample was removed and disposed of. The same analyst removed the unlabeled chemicals from one hood.
Conclusion:	Remediation accepted
Section:	Crime Scene
Issue:	The vehicle processing bay is cluttered. General cleanliness is not apparent, and the first-aid kit was not easily accessible.

Remediation: The vehicle processing bay has been cleaned and decluttered.
Conclusion: Remediation accepted
